



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS ORTHOPEDIC HOSPITAL
c/o HOLLAWAY & GUMBERT
3701 KIRBY DRIVE, SUITE 1288
HOUSTON TX 77098-3926

Carrier's Austin Representative Box

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MFDR Date Received

September 22, 2008

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-09-0281-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor (SLRF) of 75%...therefore, the fees paid by Carrier in this case do not conform to the reimbursement section of Rule §134.401. Pursuant to the DWC fee guidelines, this claim should have been paid as follows: Total Billable Charges \$148,687.38, Less Personal/Non-Related Items \$0.00, Less On-Site Audit Reductions \$No On-Site Audit, Less SLRF Reduction of 25% \$37,171.85, Total allowable \$111,515.53, Amount paid \$89,212.43, Balance Due \$22,303.10."

Amount in Dispute: \$22,303.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor believes it is entitled to the stop loss exception because its bill is in excess of \$40,000.00. Texas Mutual does not. The requestor has the burden of proof to demonstrate that the ten day period of treatment was unusually extensive and unusually costly."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
October 9, 2007 through October 19, 2007	Inpatient Hospital Services	\$22,303.10	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.401, 22 Texas Register 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital for the date of admission in dispute.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- CAC – B5 Payment adjusted because coverage/program guidelines were not met or were exceeded
- CAC – W1 Workers' Compensation State Fee
- 480 – Reimbursement based on the acute care inpatient hospital fee guidelines

Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each party was given the opportunity to supplement their original MDR dispute submission, position or response as applicable. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection." 28 Texas Administrative Code §134.401(c) (6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c) (6) (A) (i) states "to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed." Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c) (6) (A) (v); therefore the audited charges equal \$148,687.38. The division concludes that the total audited charges exceed \$40,000
2. The requestor in its original position statement asserts that "Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40k, the entire admission will be paid using the stop-loss reimbursement factor (SLRF) of 75%..." The requestor asserts that it is entitled to the stop loss method of payment. As noted above, the Third Court of Appeals in its November 13, 2008 opinion concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved...unusually extensive services." The requestor failed to demonstrate that the particulars of the admission in dispute constitute unusually extensive services compared to similar services or admissions; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).
3. In regards to whether the services were unusually costly, the requestor presumes that because the bill exceeds \$40,000, the stop loss method of payment should apply. The Third Court of Appeals in its November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must **demonstrate** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to demonstrate that the

particulars of the admission in dispute constitutes unusually costly services; therefore, the division finds that the requestor failed to meet 28 Texas Administrative Code §134.401(c) (6).

4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c) (1) titled Standard Per Diem Amount and §134.401(c) (4) titled Additional Reimbursements. The division notes that additional reimbursements under §134.401(c) (4) apply only to bills that do not reach the stop-loss threshold described in subsection (c) (6) of this section.
 - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that “The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission.” The length of stay was ten days. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of ten days results in an allowable amount of \$11,180.00.
 - 28 Texas Administrative Code §134.401(c)(4)(C) states “Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time.” A review of the submitted itemized statement finds that the requestor billed five units of Hydromorphone 20MG/100, at \$454.75 per unit. The requestor did not submit documentation to support what the cost to the hospital was for this drug. For that reason, reimbursement for these items cannot be recommended.
 - 28 Texas Administrative Code §134.401(c)(4)(A), states “When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274).” Review of the requestor’s medical bills finds that the following items were billed under revenue code 0278 and are therefore eligible for separate payment under §134.401(c)(4)(A) as follows:

Code	Itemized Statement Description	Cost Invoice Description	UNITS / Cost Per Unit	Total Cost	Cost + 10%
0278	Cement Simplex	Simplex PFullDose 10Pack	3 / \$580	\$1,740.00	\$1,914.00
0278	Clip Hemoclip	No Cost Invoice Found	2 Not Supported	Not Supported	Not Supported
0278	SNI Rng Ful 180	Full Ring 180 MM	1 / \$504.73	\$504.73	\$555.20
0278	SNI Rng ½ 180	Half Ring 180 MM	1 / \$458.54	\$458.54	\$504.39
0278	SNI Rng FT 180L	Foot Ring 180 MM Long	1 / \$550.08	\$550.08	\$605.09
0278	SNI PLT SH 55 4H	No Cost Invoice Found	1 Not Supported	Not Supported	Not Supported
0278	SNI PLT SH 85 7H	No Cost Invoice Found	1 Not Supported	Not Supported	Not Supported
0278	SNI ROD THR 120	Thread Rod 120MM	2 / \$10.56	\$21.12	\$23.23
0278	SNI ROD THR 350	Threaded Rod 350MM	4 / \$20.64	\$82.56	\$90.82
0278	SNI HNG MAL HIPRO	No Cost Invoice Found	2 Not Supported	Not Supported	Not Supported
0278	SNI BLT ½ FX 5M	No Cost Invoice Found	3 Not Supported	Not Supported	Not Supported
0278	SNI FIX BOLT SLOT	No Cost Invoice Found	24 Not Supported	Not Supported	Not Supported
0278	SNI BOLT 16MM	Bolt 16MM	14 / \$1.45	\$20.30	\$22.33
0278	SNI ANCH 2MM	No Cost Invoice Found	1 Not Supported	Not Supported	Not Supported
0278	SNI ANCH 4MM	No Cost Invoice Found	3 Not Supported	Not Supported	Not Supported
0278	SNI NUT 10MM	NUT 10MM	84 billed, 38 Supported / \$1.45	\$55.10	\$60.61
0278	SNI NUT 4PT D/C	DC Counter 4 Point	10 billed, 8 Supported / \$32.02	\$256.16	\$281.78
0278	SNI SOCKET THR 20	THD Socket 20 MM Length	4 / \$15.55	\$62.20	\$68.42
0278	SNI SOCKET THR 60	Threaded Socket 60MM	4 / \$28.46	\$113.84	\$125.22
0278	SNI WIRE 1.8X370	No Cost Invoice Found	1 Not Supported	Not Supported	Not Supported
0278	SNI WIRE OLV 1.8	No Cost Invoice Found	11 Not Supported	Not Supported	Not Supported
TOTAL ALLOWABLE				\$4,251.09	

The division concludes that the total allowable for this admission is \$11,180.00 per diem + \$4,251.09 carve-out allowable=\$15,431.09. The respondent issued payment in the amount of \$89,212.43. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	_____	July 16, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service* demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.